Three Rivers Home Health Services, Inc.

131 Main Street ♦ P.O. Box 640
Eastman, Georgia 31023

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____

Address _____

_____

Revocation

Date Revoked: _____

I authorize Three Rivers Home Health Services, Inc. to use or disclose my health information as described below.

Person / Organization authorized to receive information: _____

Type of information authorized for release: _____

_____

_____

Purpose of information:

□ **At request of:** _____

□ **Other:** _____

Expiration date for Authorization: _____

I understand the following:

1. I have the right to revoke this authorization by notifying the Agency in writing at the above address and that if I revoke the authorization it will only affect release of further information. It will not apply to information already released.
2. I understand that there is a potential for the information authorized to be subject to disclosure by the recipient, and in some cases, will no longer be protected health information.
3. I understand my healthcare will not be affected if I do not sign this authorization.
4. I understand I may be charged a fee as allowed by law for the information released.

_____ _____
Signature of patient / representative Date

_____
Print name

_____
Personal Representative's Title (e.g., Guardian, Power of Attorney)